Diagnosis Coding for Medicare Home Health under PPS

The purpose of this document is to assist home health agencies in understanding correct diagnosis coding practices for Medicare home health. The materials that follow are in three sections: (1) information on general coding principles, with discussion of coding issues pertinent to home health (2) case scenarios for illustration, and (3) Frequently Asked Questions (FAQs) on diagnosis coding. Questions about specific cases agencies encounter in their clinical practice should be referred to the agency's Medicare fiscal intermediary or national/local coding authorities such as the American Health Information Management Association (AHIMA).

Note: Source materials for this document include the following: (1) Medicare Home Health Manual, or HIM-11, including billing instructions and instructions for completing the HCFA-485, Plan of Care (see http://www.hcfa.gov/pubforms/p2192ch1.htm for information about obtaining a manual); (2) OASIS User's Manual, Chapter 8 (available via http://www.hcfa.gov/medicaid/oasis/usermanu.htm#impmanual; (3) the ICD-9-CM manual and official coding guidelines, available from commercial sources and from the U.S. Centers for Disease Control (for the manual, see http://www.cdc.gov/nchs/products/catalogs/subject/icd/icd96ed.htm; for official coding guidelines, see http://www.cdc.gov/nchs/data/icdguide.pdf).

General coding principles and coding issues for Medicare home health

A. General Coding Principles

1. Introduction

The logic for determining the primary (first-listed) diagnosis for Medicare home health claims, OASIS M0230/M0240 (Diagnoses and Severity Index), and the HCFA-485 (Plan of Care) remains unchanged under home health prospective payment (PPS). The agency determines the primary diagnosis based on the condition that is most related to the current plan of care. According to the HIM-11 instructions on determining the primary diagnosis, "the diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered." It is important to note that skilled services (skilled nursing, physical, occupational, and speech therapy), not unskilled services, are used in judging relevancy of a diagnosis to the plan of care.

The secondary diagnoses are again determined using HIM-11 logic. The HIM-11 says, "Enter all pertinent diagnoses . . . relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or which developed subsequently. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care." How inclusive should the list be? This is something of a gray area. In general, include not only conditions actively addressed in the plan of care, but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome.

After the agency determines the primary diagnosis and other diagnoses, the agency must select the codes to report them. Rules for selecting codes come from both OASIS requirements and ICD-9-CM guidelines and requirements. In some instances these sources will conflict. How does the agency resolve conflicts between the sources? OASIS takes the highest priority in deciding among conflicting results. This is because the home health case mix system was developed using the OASIS diagnosis coding instructions, and because violations may cause rejections by the state agency.

2. OASIS requirements

OASIS does not allow surgical codes, V-codes, and E-codes. This raises a problem for coding for OASIS M0230/M0240 (Diagnoses and Severity Index) in most post-surgical cases where care of the surgical wound is the reason for home care admission. No diagnosis codes are available in the ICD-9-CM system to describe an uncomplicated surgical wound. Without the OASIS restriction, a V-code for post-operative wound care would often be used in this common scenario.

In response to this quandary, a common error is to report a code for an open wound injury from Chapter 17, Injury and Poisoning, of the ICD-9-CM Manual. For example, early Medicare PPS claims data included a large number of claims for amputations from Chapter 17; most of these must be errors because almost all amputations result from medical treatment rather than accidents. Similarly, many wounds in the Medicare home care population are the intentional result of medical treatment. Coding surgical wounds and medical amputations using Chapter 17 open wound codes is a mistake because those codes are reserved for injuries (from accidents or violence). Medically caused wounds should never be included in that category, unless they have complications as discussed below.

If the agency, in accordance with OASIS instructions, selects a code for the condition that led to the surgical wound, the result may be a diagnosis that the patient no longer has. Nevertheless, when a patient is admitted to home care mainly for surgical wound assessment and treatment, the condition responsible for the surgery is often the only primary diagnosis available for use on OASIS. For example, on OASIS, it is correct to report lumbar intervertebral disc displacement (722.10) as the primary diagnosis in the case of a successful laminectomy, even if the patient after surgery is considered cured. Frequently a fracture leads to a surgical wound. Wound cases due to surgical hip fracture repair generally use a fracture code taken from the injury chapter if an accident or fall was the cause. (Note that surgical procedures are not now, and never have been, acceptable as the primary diagnosis for the patient receiving home care.)

In the case examples section below we describe a few scenarios where some other diagnosis can be used instead of the pre-surgery one, but agencies should not expect that type of solution to be available in most instances. (See the section below on proper use of Chapter 16 symptom codes and case examples 9-11, 20-21.) Occasionally, a post-operative infection or other surgical complication (coded from categories 997-999 at the end of Chapter 17) may be usable and would not lead to what seems to be an outdated diagnosis. Agencies may be tempted to stretch the definition of a complication as a means of solving a coding dilemma, but they should avoid this. For example, the presence of a surgical drain is a normal, routine part of care for some surgical wounds, and does not necessarily indicate a complication. Codes for complications of medical and surgical care should only be reported when the patient's physician has documented a complication.

Although OASIS prohibits the use of surgical and V-codes, the agency may use such codes on the HCFA-485 and on the UB-92 claim form, as long as the agency follows instructions in the HIM-11 for proper placement of such codes. The HIM-11 instructions also state that the first two listed diagnoses must match across all three documents—the OASIS M0230/M0240, the HCFA-485, and the UB-92. To meet this requirement, lower-listed diagnoses coded with V-codes may be reported in Box 21 of the HCFA-485, and below the second diagnosis on the UB-92. Beware that the agency should never leave a gap in the diagnosis listing on the UB-92. This means that if the only applicable diagnosis after the primary diagnosis is a V-code, it must be omitted from the UB-92's list of diagnoses, because an agency can't leave a blank within a list of codes. Also to be

avoided is "forcing" the HAVEN software to accept a V-code by dropping the leading letter "v" during data entry; this will cause an erroneous code for an infectious disease.

3. Using the ICD-9-CM manual to select diagnosis codes

The proper use of the ICD-9-CM manual to select diagnosis codes involves two steps. First, the agency looks up the disease in the alphabetic index to diseases. Second, the agency verifies the code selected by finding it in the tabular list. The tabular entry may contain instructions for additional coding, sequencing, exclusions, fourth- or fifth-digit coding, or other notations. Agencies should never rely on either section of the manual alone.

When consulting the alphabetic index, several listed codes may seem applicable at first. To determine which one is correct, consult the tabular list. In reviewing the tabular list, pay attention to the chapter and subsection in which a code appears. This can help point to the correct code when several alternatives may appear suitable. For example, quadriplegia can be coded from several different sections of the manual—cerebral occlusion, other CVD, other paralytic syndromes, or fractures of the neck and trunk.

Another important function of the tabular list is to explain how detailed the coding of a particular condition must be. For example, additional codes or digits may be required. Agencies should follow these manual directions to ensure their coding is complete. Although OASIS instructions do not require fourth or fifth digits, the PPS Final Rule advised agencies to use them. Full-digit coding on OASIS M0230/M0240 will improve the national database for home health payment research, and it eventually may be required under law. With few exceptions, a proper code has either four or five digits, and a four-digit code is not correct when use of a fifth digit is indicated in the tabular list.

B. Issues in Medicare Home Health Diagnosis Coding

1. Manifestation codes

In certain cases, ICD-9-CM calls for more than one code to report a condition; this requirement, termed "multiple coding of diagnoses", often involves both a disease and one of its manifestations. The ICD-9-CM manual clearly shows the instances where manifestation coding is required.

Manifestation coding affected some of the case mix system's diagnosis groups. The PPS Final Rule listed certain manifestation codes carrying points under the case mix system. To receive points, the codes must appear in their proper sequence as the first secondary diagnosis. (To receive points, they must also appear with all required digits.) ICD-9-CM sequencing requirements for manifestation codes are indicated in two ways in the manual. First, manifestation codes are indicated in the index to diseases where two codes are listed after a specific condition, with the second code in brackets. Second, manifestation codes are indicated in the tabular list where codes appear in italicized letters. Codes italicized in the tabular list can never appear in the primary diagnosis field, and must be preceded by

the code for the underlying condition. Every italicized code in the tabular list is accompanied by instructions to report the code for the etiology first.

For example, an agency, following the HIM-11 logic, may determine that the primary reason for home care in a patient with polyneuropathy is polyneuropathy due to chronic renal failure. The entry in the ICD-9-CM manual's alphabetic index under "polyneuropathy" shows a subcategory called "in uremia" with two codes, as follows: 585 *[357.4]*. The first code (585) is for the diagnosis "chronic renal failure," and the second code (357.4) is for the diagnosis "polyneuropathy." Placed in brackets in the alphabetic index, the second code is a manifestation of the disease chronic renal failure. The entry for 357.4 in the ICD-9-CM manual's tabular list shows "*357.4, Polyneuropathy in other diseases classified elsewhere*" in italics followed by the instruction, "*Code first underlying disease, as:*". The instruction is followed by examples of possible underlying conditions, including uremia. According to ICD-9-CM rules, this is an instance of "multiple coding" for a single diagnosis; in this case, the agency is instructed to report separate codes in a specified order for both the etiology and the manifestation of the disease.

A common example of manifestation coding in home care is diabetic ulcers. The alphabetic index lists diabetic ulcers under "diabetes, ulcer (skin)." This entry shows two codes, as follows: 250.8x *[707.9]*. The first code is for the diagnosis "diabetes with other specified manifestations." (The "x" means a fifth digit is required. The tabular list explains how to determine the fifth digit.) The second code is for the diagnosis "chronic ulcer of unspecified site." Placed in brackets, the second code is a manifestation of the disease diabetes.

Manifestation codes not appearing on the Final Rule list are available for agencies to use when appropriate. All manifestation codes should be accompanied by an additional required code in the proper order. A manifestation code may be involved in reporting a secondary diagnosis. If so, the ICD-9-CM sequencing rules should be followed; in this case, two codes are used within the list of secondary diagnoses to report a single condition.

Some agencies misinterpreted the manifestation code sequencing instructions in the Final Rule. They thought the instructions meant that ALL instances where a direct cause of the need for home care is traceable to an underlying disease should be reported using the underlying disease code. The sequencing instructions in the Final Rule were only intended to apply to diagnoses coded with manifestation codes. Therefore, unless an agency encounters a manifestation code in consulting the manual, the agency should continue to list the primary reason for home care in the primary diagnosis field, as it has always done (subject to OASIS restrictions, of course).

2. Nonspecified sites

The ICD-9-CM coding system often requires the coder to specify the body part, or site, affected by a problem. The coding system also allows for situations when the coder cannot determine which site is affected by a problem. Detailed fourth- or fifth-digit

coding is used in many musculoskeletal diseases to report the site or, if the site is unknown, to report "site unspecified." Agencies are overusing "site unspecified" in orthopedic, fracture, and other cases. Agencies are familiar with such details of the case and should be able to avoid most instances of "site unspecified" coding. In general, nonspecific coding limits the usefulness of home health databases for future research into improving case mix measurement and other policy issues.

3. Stroke patients

Often in home care, patients recently discharged from the hospital for stroke are admitted for rehabilitation. In the past, agencies usually assigned the diagnosis cerebrovascular accident (436). However, ICD-9-CM guidelines state that this diagnosis should be reserved for the hospital episode. In the Final Rule for the PPS system, CMS did not prohibit this diagnosis because to do so would interfere with the accuracy of the case mix system, developed based on agency coding practices.

When should the agency switch from the acute CVA to the late-effect CVA code? While the patient continues to improve under rehabilitation therapy, it would be appropriate to report 436, stroke. Once the patient's recovery has reached a plateau, then a code from 438, late effects of cerebrovascular disease, is correct. If a patient has been discharged with goals met and later returns for a problem related to the stroke, then a code from 438 should be used.

4. Proximate diagnosis vs. underlying condition

Many coding questions in home health concern the causal chain leading to the patient's current condition and treatment, and where in the causal chain the home health diagnosis assignment should focus. Medicare instructions indicate agencies must focus on the diagnoses that directly explain the need for home care. Moreover, except in multiple/ manifestation coding, the ICD-9-CM guidelines do not direct users to report the root cause of a patient's health problems when a more proximate diagnosis is available. The following are some examples of correct proximate diagnoses in patients with an underlying condition:

- neurogenic bladder in a stable MS patient
- radiculitis in a stable MS patient
- abnormality of gait in a recent amputee who had gangrene due to diabetes
- Raynaud's syndrome in a patient with systemic lupus erythematosus
- stroke in a patient with cerebral arteriosclerosis

In these types of cases, when the proximate diagnosis is the main reason for home care, it is reported as the primary diagnosis and the underlying condition is a secondary diagnosis. Occasionally the proximate diagnosis is taken from Chapter 16 symptom codes, as in the abnormality of gait example above. But agencies should beware of using the Chapter 16 symptom codes without first carefully checking the coding manual for the appropriate code from another chapter of the coding manual. More on this topic follows.

5. Proper use of Chapter 16 symptom codes

Symptoms appear commonly throughout the ICD-9-CM coding system. For example, a code for dysphagia appears in the sections on mental disorders, circulatory system diseases, digestive system diseases, gastrointestinal diseases, and diseases of the blood-forming organs. ICD-9-CM incorporates symptom codes as two basic types: codes for diagnoses that prominently feature a certain symptom and codes simply naming a symptom in a more or less freestanding mode. The latter type is usually found in Chapter 16, "Symptoms, Signs, and Ill-defined Conditions." Except for these Chapter 16 codes, a symptom is associated with a diagnosis classified elsewhere in chapters dealing with infections, neoplasms, or a specified body system.

Whenever possible agencies should avoid reporting Chapter 16 symptom codes as the primary diagnosis unless 1) the medical diagnosis has not been established, 2) using a Chapter 16 code avoids using an outdated diagnosis associated with the recent hospitalization, or 3) reporting some other diagnosis would portray the case inaccurately in terms of the HIM-11 instructions.

Medical diagnosis not established. ICD-9-CM guidelines stipulate that symptom codes from Chapter 16 should only be reported when a related, definitive diagnosis has not been established. Frequently in home health a patient is admitted without accompanying documentation that would allow the agency to assign a diagnosis code other than a symptom code from Chapter 16 of the ICD-9-CM manual. If the agency cannot obtain a documented diagnosis by the time the OASIS must be completed, the agency should report the symptom as the primary diagnosis. Sometimes a symptom from Chapter 16 must be assigned because the symptom is not clearly attributable to known diseases afflicting the patient. For example, in some elderly patients with incontinence, the incontinence may be due to one of several diseases or conditions, such as prostate problems, nerve damage, bladder obstruction, urinary tract infection, or medications. The physician is responsible for determining whether there is a cause-effect relationship. If a documented diagnosis related to the symptom later becomes known, the agency may correct the UB-92, update the HCFA-485, and report the documented diagnosis on the next scheduled OASIS, if any. (Since OASIS reflects the patient's status at the time of the assessment, it is not necessary to submit a correction to the original code reported in M0230/M0240.)

Avoids use of an outdated diagnosis. As noted earlier, OASIS restrictions sometimes leave agencies in a position of reporting a diagnosis that no longer strictly applies. The agency may find that a symptom code more accurately portrays the primary reason for home care, and may wish to use a symptom code as a better choice than the inapplicable diagnosis. Therefore, symptom codes from Chapter 16 have a potentially important role to play, especially when nursing care and/or rehabilitation is the focus of treatment but no current disease condition is appropriate to report. For example, "shortness of breath" might be appropriate when an infirm, elderly patient is admitted for supportive care after a hospitalization for pneumonia. By the time of home care admission, pneumonia may no

longer be a current diagnosis, and it is not the reason for home care, although it is certainly part of the patient's recent medical history. To avoid coding a diagnosis that was resolved earlier, a symptom code may be the best choice. As another example, "symptoms involving skin and other integumentary tissue" and "symptoms involving nervous and musculoskeletal systems" are available in Chapter 16 and can be used in certain orthopedic rehabilitation cases. For instance, when a patient is admitted status-post laminectomy for physical therapy, a symptom code for "numbness" or "paresthesia" (782.0) may apply. However, the agency is not required to use the symptom code, as long as the diagnosis selected satisfies the OASIS instruction to report the condition underlying the surgery. In post-laminectomy, the OASIS instruction would be satisfied by the indication for the laminectomy, such as spinal stenosis (724.02), degeneration of intervertebral disc (722.52), etc. (Note that OASIS instructions do not prevent the agency from reporting a more current diagnosis such as the numbness symptom, if it describes the primary reason for home care.)

Avoids portraying the case inaccurately. In home health practice, the skilled needs of certain patients with severely disabling chronic conditions such as multiple sclerosis, Alzheimer's disease, and Parkinson's disease are often very limited. In many cases, the agency has addressed multiple medical needs arising during an exacerbation of the condition, but continues to serve the patient for a single remaining aspect of the condition. The coding system does not always provide a code that features the aspect within the larger context of the underlying condition. (An example of a code that explicitly incorporates an aspect of a condition is 438.22, the code for late effect of cerebrovascular disease-hemiplegia affecting nondominant side; this code describes an aspect of stroke.) When the patient is receiving home care for only one aspect of a chronic condition, and there is no code for the condition that explicitly incorporates the aspect, then a Chapter 16 symptom code may be the best code meeting the HIM-11 requirements to report the primary reason for home care. While ICD-9-CM guidelines do not envision using Chapter 16 symptom codes in this manner (the guidelines stipulate that Chapter 16 codes should only be reported when a related, definitive diagnosis has not been established), this approach is consistent with past agency practices and satisfies the HIM-11 requirement to point to the reason for care. Also, this approach reserves major chronic condition codes for care plans that more fully address the multiple implications of the serious disease being reported.

For example, an Alzheimer's patient and his family have been receiving home care due to deteriorating neurological status requiring medication teaching, patient and caregiver education, safety assessment, and ADL training. The correct primary diagnosis is Alzheimer's disease. After the agency determines that treatment goals are met, the Alzheimer's patient is discharged, only to be readmitted soon thereafter because dysphagia has required the physician to order a feeding tube. By this time, Alzheimer's disease is no longer the focus of treatment; the only focus now is establishing the patient with the feeding tube. Therefore, a Chapter 16 symptom code for dysphagia is assigned.

Another example is the reporting of urinary retention in a patient with multiple sclerosis causing the urinary retention. If the plan of care for skilled services simply involves

nursing visits to treat the urinary retention with a Foley catheter change, the agency should report the code that portrays this aspect of the disease. Usually the correct diagnosis is neurogenic bladder, and the agency should ask the physician about it. If neurogenic bladder is not documented even after consulting with the physician, then the Chapter 16 code for urinary retention should be used to reflect a plan of care limited to treating the urinary retention. Agencies should reserve the multiple sclerosis code for cases where the plan of care is broad and intensive enough to address multiple problems and needs of the patient--for example, a patient with a recent exacerbation of the disease.

A word about Chapter 16 symptom codes as secondary diagnoses: Using a Chapter 16 symptom code as a secondary diagnosis is a common practice in home care. This is entirely appropriate when the symptom code describes an important aspect of the patient's condition, provided two conditions are met. The first is that the symptom code is not used in place of a documented diagnosis classified elsewhere in the coding system. For example, if the patient has abnormal sputum (code 786.4 from Chapter 16), this should not be used in place of a secondary diagnosis of bronchitis if the plan of care is to address the patient's bronchitis. Second, the symptom reported should not be part and parcel of the diagnosis it is intended to support. For example, experts generally consider edema to be integral to the diagnosis of congestive heart failure. Therefore, reporting edema in addition to CHF is superfluous.

C. Summary

In summary, the primary diagnosis and secondary diagnoses should be determined according to HIM-11 instructions. Under OASIS reporting restrictions, agencies should report the medical diagnosis relevant to the surgery for M0230/M0240 when V-codes for post-operative wound care would otherwise be used. Agencies should reserve injury and poisoning codes (categories 800-995) for injuries from accidents or violence. Surgical complications codes are available, but agencies should not use them inappropriately to fill the gap left by the OASIS restrictions. Agencies should observe the explicit diagnosis sequencing instructions in ICD-9-CM, to ensure that manifestation codes are not erroneously reported as the primary diagnosis (or out of sequence when multiple coding is used to report a secondary diagnosis). Fourth- and fifth-digit coding should be followed, notwithstanding that OASIS doesn't require it, and agencies should specify the site/region of the body rather than coding "unknown." Under Medicare home health PPS, the major exceptions to ICD-9-CM coding guidelines involve the use of acute stroke codes and symptom codes from Chapter 16. Agencies should recognize the appropriate uses of Chapter 16 symptom codes but not overuse them.

Case examples for diagnosis coding

Important: Diagnoses are listed in correct order. The character "x" in a diagnosis code is a placeholder for an additional digit. When V-codes are indicated, they should be reported only on the HCFA-485 and/or UB-92, following HIM-11 and billing instructions for placement. Case examples from AHIMA appear here in modified form.

Case 1: Diagnosis "representing the most acute condition and requires the most intensive services": Foley catheter care for bladder problem secondary to MS

A 56 year old woman with multiple sclerosis for the past 30 years has decreased visual acuity and some impaired mobility, balance, and fine motor control, all of which have been relatively stable in recent months. She requires home health care for the management of her neurogenic bladder, which is causing urinary retention and is managed with a chronic Foley catheter. A nurse comes every three to four weeks to change the catheter, perform other care associated with the Foley catheter, and monitor her for signs of urinary tract infection.

ICD-9-CM coding: 596.54, neurogenic bladder; 340, multiple sclerosis; V53.6, Foley catheter change

Discussion: Use primary diagnosis of 788.20, urinary retention, if physician does not diagnose neurogenic bladder. Use primary diagnosis of 340, multiple sclerosis, if the patient is being seen for more than one aspect of this chronic condition.

Case 2: Primary diagnosis of multiple sclerosis exacerbation

Patient with an acute exacerbation of multiple sclerosis is experiencing an ambulation deficit as well as an ADL deficit. The patient has a neurogenic bladder and requires a Foley catheter insertion. The physician has changed the patient's medications and ordered home health skilled nursing visits for Foley catheter insertion, neurological assessment, safety instruction, and assessment of medication regime, twice per week for four weeks, then monthly for Foley catheter change. The physician has ordered physical therapy for therapeutic exercises, safety instruction, gait training with walker, and establishment of home exercise program. The MD has also ordered occupational therapy for ADL training, functional mobility, safety instructions, and homemaking skills.

ICD-9-CM coding: 340, multiple sclerosis; 596.54, neurogenic bladder; V53.6, Foley catheter change; V57.1, physical therapy; V57.21, occupational therapy.

Discussion: The recent exacerbation of the MS, requiring multiple skilled interventions, explains the primary diagnosis of MS. The diagnosis for gait abnormality is not necessary because the codes for MS and physical therapy sufficiently describe the patient's status.

Case 3: Selecting a primary diagnosis (from AHIMA)

A 67 year old male with severe Alzheimer's and a seizure disorder had a recent bout of aspiration pneumonia that sent him to the hospital. He has been very debilitated for years, is nonverbal, contracted, and needs 24-hour care. Previously he had eaten by mouth. The home health agency had just discharged him when he aspirated. The patient is now being readmitted. He has a gastrostomy tube with continuous tube feedings due to difficulties in swallowing. The nurse will see him two to three times per week to teach his wife to administer tube feedings, make sure his care needs are being met, and assess respiratory status. He has a personal care assistant who lives in the house and assists with his care. His wife also provides much of his care. Therapy is not appropriate at this time.

ICD-9-CM coding: 787.2, dysphagia; 780.39, seizure disorder; 331.0 Alzheimer's disease; V55.1, attention to gastrostomy

Discussion: At this stage of the case history, the fundamental reason for services is to teach the wife to administer the tube feedings, which are needed to avoid a recurrence of the aspiration pneumonia. This is an example where Medicare requirements differ from ICD-9-CM coding rules, which say that if the swallowing problem is due to the Alzheimer's, then the Alzheimer's should be the primary diagnosis. The secondary diagnoses are listed because they influence the course of treatment. The seizure disorder is more acute than the Alzheimer's, so it is listed before it. Aspiration pneumonia wasn't coded and reported for this scenario because it wasn't clear if the patient still had symptoms. If the condition has not resolved (for example, the patient is still on antibiotic treatment), a code for pneumonia would also be assigned.

Case 4: Explicit ICD-9-CM manual sequencing: Diabetes with other specified manifestations (from AHIMA)

A 72 year old man with uncontrolled non-insulin dependent diabetes mellitus and diminished visual acuity has a diabetic ulcer over his left first metatarsal head for the past two months. Although he is seen regularly by a podiatrist, a nurse visits him three times weekly to monitor the wound and change dressings. His diabetes is relatively stable, and he has received adequate counseling about management of his diabetes mellitus in the past.

ICD-9-CM coding: 250.82, type II diabetes with other specified manifestation; 707.14, ulcer due to diabetes ("ulcer of heel and midfoot"); a diagnosis coded from category 369, blindness and low vision

Discussion: The primary reason for home health care is diabetic ulcer. Diabetic ulcer is coded according to specific sequencing instructions given in the index to diseases, and this sequence is used here. The fifth digit of the diabetes code signifies control status and type I/II. There is no specific treatment in the plan of care directed at the impaired vision; however, we include it here because we assume that the frequency and intensity of nursing visits are influenced by the presence of poor vision. If the plan of care were not

influenced by the vision status, then the diagnosis would be omitted. There is a diabetes code to include if the vision problem is known to be a result of the diabetes (250.52, diabetes with ophthalmic manifestations). In that case, the diagnosis coding sequence would be: 250.82, 707.14, 250.52, 369.xx (i.e., two problems are coded with a total of four codes, as these are examples of multiple coding specifically following instructions in the ICD-9-CM manual). If the physician doesn't attribute the foot ulcer to the diabetes, then the primary diagnosis would be 707.14, ulcer of heel and midfoot.

Case 5: Diabetes with multiple manifestations, manifestation coding required (from AHIMA)

A 79 year old patient has uncontrolled diabetes type I. She is legally blind and has diabetic retinopathy. Other diagnoses are CHF, peripheral vascular disease due to diabetes, and pleural effusion. Patient lives with her elderly husband who is in poor health. There are no close relatives near by. The skilled nursing services include wound care to the chronic diabetic ulcer on the left foot; prefill syringes, administer insulin every day, fingerstick every week and PRN for signs and symptoms of hypo/hyperglycemia; teach diabetic foot care regimen; and monitor medication regimen.

ICD-9-CM coding: 250.83, diabetes with other specified manifestations; 707.15, diabetic ulcer ("ulcer of other part of foot"); 250.73, diabetes with peripheral circulatory disorders; 443.81, peripheral vascular disease due to diabetes ("peripheral angiopathy in diseases classified elsewhere"); 250.53, diabetes with ophthalmic manifestations; 362.01, diabetic retinopathy; 428.0 (congestive heart failure); 511.9 (unspecified pleural effusion); 369.4 (legal blindness)

Discussion: The primary diagnosis relates to the diabetic ulcer, the most acute condition in this case. 443.81 and 362.01 are "manifestation" codes, i.e., they are italicized in the tabular list and must be preceded by the underlying disease code (here, the diabetes with peripheral circulatory disorders and the diabetes with ophthalmic manifestations)

Case 6: Diabetes as a secondary diagnosis: Medical hospital discharge with asthma management, in patient with mild dementia and diabetes.

A 72 year old woman, recently discharged from the hospital after an exacerbation of her extrinsic asthma, was provided at discharge with a nebulizer to improve her medication management. Because she also has a mild senile dementia, skilled nursing services were ordered to teach her and her husband to utilize the nebulizer and to assure medication compliance. She will also be taught to use a home incentive spirometer to monitor her response to the medication. The nurse will also assure compliance with her other medications for hypertension and stable type two diabetes mellitus, treated with oral medication. Because her asthma medications include an inhaled corticosteroid, the physician asks the nurse to review the patient's logs of blood glucose, which the patient checks twice weekly.

ICD-9-CM coding: 493.00, extrinsic asthma; 290.0, senile dementia, uncomplicated; 250.00, diabetes mellitus without mention of complication; 401.9, essential hypertension, unspecified

Discussion: Fifth digit of asthma code signifies with/without mention of status asthmaticus. The senile dementia precedes the other chronic conditions in the secondary diagnosis listing, because it more strongly influences the overall treatment plan. Diabetes is present and responsible for glucose- and medication-monitoring activities, but it is not the main reason for home health care, and so it is listed as a secondary diagnosis lower down in the list.

Case 7: Diabetic patient with stasis ulcer (from AHIMA)

The patient is a 72 year old female with chronic stasis ulcer of the leg, but she also has 3 diabetic toe ulcers at this time. Patient has chronic lower extremity edema, CHF, HTN. She has daily caregivers through the Medicaid program. The nurse is seeing her 3 times per week to change leg dressings (using Polymem and covering with stretch bandage), monitor/adjust medications, teach medication management, and teach caregivers to provide low sodium diet, keep leg elevated. The nurse hopes to teach a neighbor to change the dressing at least once per week. Physical therapy is ordered every other week for exercise, transfer training, and gait training. Patient ambulates minimally, only with close assist and walker. She needs assistance with all ADLs.

ICD-9-CM coding: 454.0, stasis ulcer of the leg; 250.80, diabetes with other specified manifestations; 707.15, diabetic ulcer of toe; 428.0, congestive heart failure; 401.9 hypertension; V57.1, physical therapy

Discussion: The most intensive skilled service is provided to the leg dressing related to the stasis ulcer. The stasis ulcer is the appropriate principal/primary diagnosis rather than diabetic ulcer, since the documentation indicates she has a stasis ulcer. The diabetic toe ulcers are reported using the coding sequence 250.80, 707.15. Edema would not be coded and reported because it is integral to CHF. ICD-9-CM coding guidelines indicate that conditions integral to a diagnosis are not coded separately. The CHF and HTN are mentioned as secondary diagnoses because they contribute to the need for medication management and physical therapy.

Case 8: OASIS prohibition on V-code: Breast cancer surgery patient

A 66-year-old left-handed woman is discharged from the hospital three days after a right, modified radical mastectomy for breast cancer. Her only medications are oral tamoxifen and pain medications. Skilled nursing is prescribed for management of the surgical wound, which has a surgical drain not scheduled to be removed for several days. The patient lives alone and has residual dysfunction of her left arm after a stroke. The nurse will also supervise the patient's performance of the exercises ordered to improve her shoulder range of motion on the affected side and to monitor for the development of lymphedema in her arm.

ICD-9-CM coding: 174.9, malignant neoplasm of female breast, unspecified; 438.31, late effects of cerebrovascular disease, monoplegia of upper limb; V58.3, attention to surgical dressings and sutures; V58.49, other aftercare following surgery.

Discussion: The breast cancer is the primary diagnosis because it accounts for the main home health treatment activity, care of the consequent surgical wound. In addition, the breast cancer is not resolved, as evidenced by the tamoxifen treatment. The diagnosis of neoplasm will vary depending on patient's type of neoplasm, (i.e., ICD-9-CM code of 217 would be indicated if the neoplasm was determined to be benign). The first secondary diagnosis will vary depending on the conditions that coexist at the time the Patient's Plan of Care is established, or which have developed subsequently, or that affect the treatment of care. These diagnoses are listed on the Plan of Care in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. The diagnosis responsible for the patient's inability to perform the wound care, late effect of CVD, is reflected as a secondary diagnosis. The patient may not necessarily have a physical inability to perform the wound care. (If she is incapable of performing the procedure due to a learning deficit or a refusal this requires documentation of the skilled nurse's attempts to teach and the result of the teaching.) The fifth digit for late effects signifies dominant /non-dominant/non-specified side. V58.49 is appropriate because the skilled nurse is monitoring for lymphedema and assisting/supervising the patient's exercises. The V-codes are utilized as the second and third secondary diagnoses and therefore are compliant with HIM-11 instructions.

Case 9: Post-surgical cancer patient with colostomy complication

A patient comes home from the hospital following abdominal surgery for cancer of the colon. The patient has a colostomy and also an opening around the colostomy, which requires wound care. The care being given and taught is directed at the open wound.

ICD-9-CM coding: 569.69, other complication of colostomy and enterostomy

Discussion: This is not a routine post-operative colostomy case. In a routine post-operative colostomy case, OASIS guidance for M0230/M0240 says to consider the colon cancer as the primary diagnosis, because V-codes for surgical aftercare or other rehabilitative treatments are not used on OASIS. However, in this instance, the patient appears to have a complication of the colostomy. A V-code for attention to artificial openings (colostomy), V55.3, is appropriate to add as a secondary diagnosis on the HCFA-485 (Box 21) if the home care also involved cleansing the colostomy, but the case as written makes no mention of such activity.

Case 10: Post-surgical cancer patient with an infection of colostomy

The patient is a 74 year old woman status-post resection of her large bowel and rectum with a colostomy, following bowel cancer surgery. She has an infected

draining stoma wound at the colostomy site as well as peristomal skin irritation. She requires skilled nursing care to promote wound healing and monitor the patient's colostomy care regimen.

ICD-9-CM coding: 569.61 infection of colostomy; V55.3, attention to artificial openings-colostomy

Discussion: As in Case 9, a primary diagnosis of cancer is not used because there is a more appropriate diagnosis available, infection of colostomy. If the patient's physician indicates that the patient will be undergoing chemotherapy for the bowel cancer, a malignant neoplasm diagnosis would be added as a secondary diagnosis.

Case 11: Post-surgical colitis case with a complication of colostomy

The patient is a 74 year old woman who had ulcerative colitis before undergoing a resection of her large bowel and rectum with a colostomy. The colostomy site, which had initially healed well, now has a wound in the stoma, which is leaking, with peristomal skin irritation. She requires nursing care to clean and heal the stoma wound, relieve the peristomal irritation, and assess changes in colostomy appliances and supplies.

ICD-9-CM coding: 569.69, other complication of colostomy and enterostomy, V55.3, attention to artificial openings-colostomy

Discussion: There is no mention of infection, so no code for infection was included. An ulcerative colitis diagnosis is not applicable, since colitis is not mentioned as a continuing condition and there is an appropriate primary diagnosis code available. If the patient's condition was uncomplicated and the only skilled need was to teach colostomy care, then the best available diagnosis would be a code from category 556, ulcerative colitis, with V57.89, other specified rehabilitation procedure, added as a secondary diagnosis.

Case 12: Ulceration in a stroke patient

A 78 year old right-handed woman who had a right middle cerebral artery stroke four years ago is being seen by home health for skin breakdown and ulceration of her left hand secondary to spasticity and hemiplegia residual to the stroke. Although she has mild residual apraxia, this was not treated during the episode.

ICD-9-CM coding: 707.8, chronic ulcer of other specified sites; 438.22, late effects of stroke - hemiplegia affecting non-dominant side; 781.0, spasticity

Discussion: Although the chronic ulcer is ultimately traceable to the stroke-related late effects, it is only an indirect effect and, therefore, the primary diagnosis is not a late effect of stroke. However, the residual hemiplegia and spasticity are secondary diagnoses because they affect the approach to treatment by limiting self-care activities. If the agency were to treat the apraxia, or if the apraxia affected the care of the patient and the patient's ability to carry out self-care for the problem condition, we

would add secondary diagnosis code 438.81, other late effects of cerebrovascular disease, apraxia.

Case 13: Avoiding improper use of traumatic injury code in sensory deficit

A 75 year old woman developed an ulcer on the plantar surface of her foot secondary to a loss in sensation after a stroke. The nurse comes to care for the wound and to teach the patient to care for it.

ICD-9-CM coding: 707.14, ulcer of heel and midfoot; 438.89, other late effects of cerebrovascular disease; 782.0, disturbance of skin sensation.

Discussion: Although initially there may have been an unrecognized injury that led to the chronic ulcer, a traumatic foot wound is not the primary diagnosis. This is because an injury was not documented and at the point home care is ordered the patient's diagnosis is most clearly described as a chronic ulcer. If the patient actually has monoplegia, then a more specific code than 438.89 is available; it is 438.4, late effect of CVD-monoplegia of lower limb affecting unspecified side. There is no code in the section for late effects of CVD that specifically cites disturbance of skin sensation as the late effect, and a notation under 438.89 says to use an additional code to identify the late effect; therefore, a secondary diagnosis (782.0), which comes from the symptom chapter, follows the late effect code. In several other types of late effects, a single code from category 438 would be sufficient.

Case 14: Proper use of traumatic injury codes: Collision with furniture in male with coronary artery disease

A 72 year old blind man with stable coronary artery disease treated with medication develops an ulcer on his right shin after hitting it on a piece of furniture. The skilled nursing care is ordered to initially care for the wound and teach the patient to care for it independently. After teaching the care, the nurse visits once every two weeks to reassess the wound healing.

ICD-9-CM coding: 891.0, open wound of knee, leg (except thigh), and ankle, without mention of complication; 414.00, coronary atherosclerosis, of unspecified type of vessel, native or graft; 369.00, profound impairment, both eyes, impairment level not further specified

Discussion: Although the wound is described as an "ulcer," it is a traumatic injury. The blindness is reported because it affects the education of the patient in caring for the wound.

Case 15: Acute CVA (from AHIMA)

A 65 year old male, admitted to the local hospital with complaints of sudden right sided weakness and speech problems, was diagnosed with acute right sided CVA. He was

discharged after 7 days of PT, OT, and ST. He was then admitted to a local skilled nursing facility for a 21-day stay. At home, the patient requires moderate assistance for bed mobility, maximum assistance for stand pivot transfers, and he cannot ambulate. The patient does have some active movement in right leg but none in right upper extremities. He cannot dress himself and has difficulty speaking. Previous history includes CABG 15 years ago, controlled HTN and controlled diabetes mellitus type II. Patient was previously independent in all skills including driving. His elderly wife has severe degenerative joint disease in both knees and poor vision. The physician orders include PT, OT, and SLP evaluation and treatment. The nurse will monitor the medication regimen.

ICD-9-CM coding: 436, acute, but ill-defined CVD; 784.5 speech problems; 401.9, hypertension; 250.00, diabetes; V57.1, physical therapy; V57.21, encounter for occupational therapy; V57.3, speech therapy

Discussion: Although he has had therapy treatment in other settings, the physician believes continuing therapy with the home health agency will result in further improvement. Because of the recent hospital stay for stroke, and the continuing rehabilitation, the patient is considered an immediate post-stroke case, so the primary diagnosis is acute CVA (as opposed to late effects of CVD). If the right-sided weakness is documented as hemiplegia, then the first secondary diagnosis would be 342.9x, hemiplegia). The chronic diagnoses of HTN and DM are additional secondary diagnoses because the nurse is monitoring the medication regimen for DM and HTN.

Case 16: Cerebral thrombosis

A 76 year old man who is right-handed begins home health treatment after being discharged from the hospital for a new right middle cerebral artery thrombotic cerebrovascular accident. He has left-sided hemiparesis and neglect. He receives physical and occupational therapy.

ICD-9-CM coding: 434.01, cerebral thrombosis with cerebral infarction; 342.92. hemiplegia affecting nondominant side; 781.8, neurologic neglect syndrome; V57.1, physical therapy; V57.21, encounter for occupational therapy

Discussion: In this case, the physician's stroke diagnosis was more specific than 436, acute, but ill-defined, cerebrovascular disease. If a patient with the same symptoms had an "old stroke" that explained the symptoms, the correct primary diagnosis is 438.22, late effect of cerebrovascular disease, hemiplegia affecting nondominant side.

Case 17: Mental health diagnosis in a patient with COPD

A 67 year old man with chronic obstructive lung disease (COPD) recently became a widower and lives alone. His physician notes that his control of COPD is unchanged but he is clinically depressed and needs to learn to perform some activities in the home with his diminished exercise tolerance. Nursing care is ordered to assess his compliance with newly prescribed antidepressants and to assess the patient's

psychological status and coping skills. Occupational therapy is also prescribed to teach the patient energy conservation techniques specific to activities of daily living.

ICD-9-CM coding: 311, depressive disorder, not elsewhere classified; 496, chronic airway obstruction, not elsewhere classified; V57.21, encounter for occupational therapy

Discussion: The depression diagnosis is primary because it is the most acute condition, and because the example indicates no recent exacerbation of the COPD. To use a code from category 492, emphysema, the physician would need to verify it. Similarly, a nonspecific code for depressive disorder, rather than a code such as 300.4, neurotic depression (depressive reaction), was chosen in the absence of explicit diagnostic information about the type of depression.

Case 18: Exploratory abdominal surgery

A 72-year-old woman had abdominal surgery for symptoms of elevated temperature, high white blood cell count, and dehydration. Infection was suspected prior to the surgery. The home health agency admitted the patient post-surgery for extensive dressing changes and assessment of healing, infection, etc.

ICD-9-CM coding: 780.6, fever of unknown origin; 288.8, other specified disease of white blood cells; 276.5, dehydration; V58.3, attention to surgical dressings and sutures

Discussion: All three presenting symptoms that led to the surgery and subsequent wound care are coded. This case example provides no information about findings of the surgery, and assumes the findings are still unavailable at the time the comprehensive assessment with OASIS is to be completed. Ordinarily, the agency would make every effort to obtain a definitive diagnosis from the physician as soon as possible to inform the plan of care. Potentially, if there were some nonspecific findings referrable to the gastrointestinal system, several alternative codes are available and preferred, such as 537.9, unspecified disorder of the stomach or duodenum; 537.3, other intestinal obstruction (duodenum); 537.9, unspecified disorder of stomach or duodenum; or 569.9, unspecified disorder of the intestine. If the agency had information suggesting that one of these gastrointestinal diagnoses were appropriate, it would be following the OASIS instruction for M0230/M0240 to report the medical condition relevant to the surgery. If the patient has unusually intensive needs for dressing changes, the agency should investigate whether a surgical wound complication is present, by conferring with the physician; however, there is not enough information given here to establish that.

Case 19: Selecting the primary diagnosis (from AHIMA)

An 82 year old female was discharged from the hospital after a myocardial infarction and cardiac arrest. She has spinal stenosis with active back pain, is B-complex deficient, and the physician started her on an anticoagulant requiring monitoring of her prothrombin time to adjust its dose. Her main problem right now is actually the back pain, though nursing is

observing/assessing her response to medications, venipuncture as ordered, etc. (twice per week for two weeks, then once per week for 7 weeks). PT is providing therapeutic exercise and training twice per week; OT is providing ADL training, adaptive equipment, and motor/sensory treatment once per week; and a home health aide is providing personal care twice per week.

ICD-9-CM coding: 724.00 spinal stenosis; 410.92, acute myocardial infarction, subsequent episode of care; 266.9 vitamin B deficiency; V58.83, therapeutic drug monitoring; V58.61, long-term (current) use of anticoagulants; V57.1, physical therapy, V57.21, encounter for occupational therapy

Discussion: Although the patient has had a recent MI, the main reason for home care services relates to the spinal stenosis. Spinal stenosis is the appropriate primary diagnosis. In coding the spinal stenosis, a more specific fifth digit should be used if the precise spinal region is known. The codes in category 410 are used for AMIs less than 8 weeks old. An AMI that is older than 8 weeks and has no symptoms should be assigned code 412; if it is older than 8 weeks and there are still symptoms, assign code 414.8. The fifth digit (=2) used with 410 indicates an episode of care subsequent to the initial one (which would usually be the hospital(s) where the AMI treatment was first performed).

Case 20: Residual difficulty walking in a post-laminectomy case

A 68 year old man had a lumbar laminectomy for spinal stenosis. Although his pain and function were improved after surgery, he still required physical therapy to regain his normal gait.

ICD-9-CM coding: 781.2, abnormality of gait; V57.1, other physical therapy

Discussion: The gait abnormality appears to be a residual effect of the spinal stenosis. Although the symptom indicated by code 781.2 results from a known cause (spinal stenosis), the symptom is coded first because it provides a clear and direct indication for the home care and it avoids reporting a condition (spinal stenosis) that presumably was cured by the surgery. If the symptom code for abnormal gait were not available, we would have used 724.02, spinal stenosis, as a default, because OASIS prohibits V-codes.

Case 21: Hip Fracture (from AHIMA)

An 83 year old very independent female fell at a local grocery store, sustaining a left hip fracture. An open reduction with internal fixation was performed 7 days ago. The patient was discharged home where her sister now cares for her. The patient is non-weight-bearing on left lower extremities but can perform supervised pivot transfers with contact guard assist in and out of bed. Her past medical history includes controlled HTN but patient currently has chronic urinary tract infection (on medication) that the nurse will be monitoring for treatment effectiveness. The physician orders the agency to provide PT for gait training and exercise 3 times per week for four weeks.

ICD-9-CM coding: 781.2, abnormality of gait; 599.0, urinary tract infection, site not specified; additional code to identify organism, if known; V57.1, physical therapy

Discussion: The treatment is directed at rehabilitation following the hip fracture and surgery. OASIS instructs home care agencies to code the relevant medical diagnosis when a V code for rehabilitation therapy (followed by a symptom code for abnormality of gait) would normally be assigned. Although the hip fracture is the medical diagnosis relevant to the surgery, and would be equally acceptable under OASIS logic, we chose abnormality of gait because it more accurately describes her current condition and need for therapy (i.e., technically, she no longer has a hip fracture, which was resolved by the hospital surgical treatment) and because the physician specified gait training. If the plan of care called for the nurse or physical therapist to also carry out wound care, then the V-code for attention to surgical dressings and sutures (V58.3) would be added.

Case 22: Resumption of post-stroke therapy after unrelated hospital stay

A 76 year old man is admitted into home health after discharge from the hospital for a gastrointestinal bleeding episode. He had suffered a new right middle cerebral artery thrombotic occlusion three weeks prior to this hospital stay, and as a result he has left-sided hemiplegia and dysphasia. On his return home, under the doctor's order he resumes treatment with physical, occupational, and speech therapy for rehabilitation after his stroke.

ICD-9-CM coding: 434.01, cerebral thrombosis with cerebral infarction; 342.90, hemiplegia, unspecified; 784.5, dysphasia; V57.1, other physical therapy; V57.21, encounter for occupational therapy; V57.3, speech therapy

Discussion: Under Medicare PPS coding guidelines, the acute stroke diagnosis still applies as long as the patient continues in the original post-stroke rehabilitation phase. With this coding, additional, secondary diagnoses to describe any resulting problems are included (342.90, 784.5). If the patient was beyond the rehabilitation phase but had similar problems that affected the plan of treatment, then the stroke would be coded from category 438, which contains codes for problems that don't have to be mentioned separately. (See Cases 8, 12, 16.) If the patient returned home with continued gastrointestinal bleeding, and the plan of care also called for monitoring it, the agency would add gastrointestinal bleeding as a secondary diagnosis (e.g., 578.9, hemorrhage of gastrointestinal tract, unspecified, or codes from other code categories in the digestive system chapter).

Case 23: Wound disruption

A 68 year old man had a lumbar laminectomy for spinal stenosis. Although his pain and function were improved after surgery, he was noted to have a wound dehiscence and superficial wound infection at his first post-operative visit. He was started on oral antibiotics and home health nursing was ordered to administer local care of the incision and monitor healing.

ICD-9-CM coding: 998.3, disruption of operation wound (dehiscence); 998.59, other postoperative infection; V58.3, attention to surgical dressings and sutures

Discussion: The decision on sequencing the first two diagnoses in this case is not clear. We placed the dehiscence first because the wound infection was characterized as superficial. In actual practice, the clinician familiar with the case would consult with the physician and review the plan of care to determine the sequence. The final decision, according to the HIM-11 guidelines, is based on how acute and service-intensive each condition is. V58.3, attention to surgical dressings and sutures, is used as a secondary diagnosis because nursing care is ordered to check on the wound healing process.

Case 24: Duodenal fistula vs. wound (from AHIMA)

A 66 year old female transferred from another agency due to closure. She has a history of gastric complaints that led to a gastric reconstruction. The patient has been hospitalized four times due to complications of abscesses and a duodenal fistula. The patient had a fistulogram yesterday when the radiologist re-inserted a tube in the fistula. It is a #10 French catheter that is attached to a drainage bag and there is bile drainage present. The tube comes out of the abdomen, through a colostomy wafer and the tube is sutured to the rim. There is excoriation of the skin around the wafer 15cm x 20cm. The patient states there is a crater of the skin under the wafer that is like a lemon shaped hole. There have been many different approaches to containing the drainage, and the patient will require assistance from the skilled nurse in managing her wound/fistula.

ICD-9-CM coding: 998.6 (persistent post-operative fistula)

Discussion: It appeared that the fistula was due to the gastric surgeries, so the code 998.6 was assigned. If this were not the case, the code 537.4 (duodenal fistula) would be assigned. The wound could be considered a non-healing surgical wound, but it is more than that. Code 998.6 describes the condition much more specifically than the code for a non-healing surgical wound. The V-code for attention to colostomy would not be appropriate, as this is not a colostomy. It is a drainage tube for which they are utilizing a colostomy wafer.

Case 25: Amputation in a patient with PVD

A patient is admitted to home health services for physical therapy three times a week due to abnormality of gait as a result of an amputation of her right foot. The amputation was necessitated by peripheral vascular disease. Home health nursing is providing wound care once per week.

ICD-9-CM coding: 781.2, abnormality of gait; 443.9, peripheral vascular disease; V57.1, physical therapy; V58.3, attention to surgical dressings and sutures; V49.73, lower limb amputation status, foot

Discussion: Although PVD is at the root of the patient's current problem—the loss of a foot by amputation--PVD is not a direct cause of the treatment need, so it is not the primary diagnosis. The primary diagnosis associated with the most intensive services is abnormality of gait, due to gait problems following amputation. A diagnosis of PVD is listed as secondary because it is still relevant, being a chronic condition with implications for the healing process and rehabilitative outlook.

Case 26: Incontinence of uncertain origin

An 86-year-old woman had a stroke three years ago and has residual left-sided hemiplegia and aphasia. She is also incontinent of urine with a history of urinary tract infections. The home health nurse visits the patient for monthly changes of her Foley catheter and to monitor her for signs of recurrent urinary tract infection.

ICD-9-CM coding: 788.30, incontinence, unspecified; 438.20, late effects of cerebrovascular disease, hemiplegia affecting unspecified side; 438.11, late effects of cerebrovascular disease, aphasia; V53.6, fitting and adjustment of urinary catheter

Discussion: There is no indication that stroke is the cause of the urinary incontinence, so the primary diagnosis is urinary incontinence from Chapter 16, Symptoms, Signs, and Ill-defined Conditions. If the urinary incontinence were attributable to the stroke, then the primary diagnosis would be 438.89, other late effects of cerebrovascular disease, followed by 788.30, urinary incontinence and perhaps other conditions or symptoms. The sequencing of the late effect of stroke followed by urinary incontinence is required by the instruction at code 438.89 to "use additional code to identify the late effect."

Frequently Asked Questions on Diagnosis Coding

1. Skilled nursing services drive diagnosis determination

Q: The HIM-11 instructs agencies to determine the primary diagnosis from the diagnosis that is most related to the plan of care. Often this is defined as the diagnosis responsible for the most intensive services. If a multiple sclerosis patient has infrequent skilled nursing visits but also numerous regular aide visits for ADL assistance, the most intensive service is the aide visits. In this case, shouldn't the primary diagnosis be multiple sclerosis?

A: No. The intensity of services in the definition of the primary diagnosis relates to the skilled services, not the unskilled services. Even though the nurse visits much less frequently than the home health aide, the skilled services are used to determine the primary diagnosis. In this case, the skilled services are the nurse services, but in other cases skilled services may include therapists. In MS patients, a common plan of care involving infrequent skilled nursing services is catheter change and urinary monitoring for these patients, leading to a primary diagnosis such as neurogenic bladder or urinary retention. The plan of care may or may not include additional visits from home health aides.

2. Proper use of injury codes

Q: Why can't we use trauma/injury codes for surgical wounds?

A: The trauma/injury codes, which come from the ICD-9-CM chapter "Injury and Poisoning", are reserved for **injuries** from accidents and violence. They include categories for fracture (800-829), dislocation, sprains, and strains (830-849), internal injuries (860-869), open wounds (870-897), and other injuries and burns (900-999). This means that surgeries and amputations performed for treating disease are **not** coded from the "Injury and Poisoning" section. A common condition in home health where a trauma code is used is fracture due to a fall or other accident. Therefore, in most cases hip fracture and other fractures treated surgically or otherwise ARE correctly coded with a trauma code (using one of the codes for fracture, 800-829).

Agencies that have erroneously coded disease-related post-surgical cases with a trauma diagnosis should submit an adjusted claim to ensure accurate payment.

3. Case of an "old stroke"

Q: If the patient was discharged from the hospital with exacerbation of a stroke that took place a year ago (the patient developed an abnormal gait as a result of a recent fall), is the primary diagnosis a stroke (acute), 436, or a late effect of a stroke (438)?

A: Unless there is documentation that the patient recently suffered another stroke, the correct primary diagnosis code is abnormality of gait, assuming that the home health

agency is primarily addressing gait disturbance. If the abnormality of gait were attributable to a fall rather than the stroke, it would not be considered a late effect of stroke. A code for late effect of stroke likely would be used as a secondary diagnosis, since the condition would tend to affect the treatment plan.

4. Proper use of diagnosis code for abnormal gait

Q: If the primary reason for admission is to provide physical therapy services for an abnormal gait resulting from another illness, such as arthritis, CVA, or Parkinson's disease, is the primary diagnosis abnormal gait or the illness?

A: Usually the correct code is the illness, especially if there is a disease code indicating a gait problem as part of the illness (e.g., see "late effects" codes for hemiplegia in cerebrovascular disease). An important criterion for selecting the illness code should be that the gait problem is a direct result--not an indirect result--of the illness. If the gait problem is an indirect result (as when an arthritis patient has joint surgery leading to the need for gait training), the gait abnormality is an acceptable diagnosis that avoids reporting a condition that no longer applies to the patient. However, under OASIS guidelines to code the condition underlying the surgery, arthritis would also be acceptable. Another criterion for selecting the illness code is whether it accurately represents the reason for home care. With Parkinson's disease, there are numerous implications of the illness that may or may not be treated in a given episode. If the single reason for home care is gait training in a Parkinson's patient, many agencies have traditionally selected gait abnormality to most accurately portray why the patient was admitted. This served to distinguish the episode from situations where the Parkinson's disease patient needs multiple treatments from nursing, therapy, etc. At this time, to be consistent with the historical data underlying the PPS system, our coding guidelines for Parkinson's are to select gait abnormality if it is the single aspect being addressed in the episode.

5. Timing of change from acute CVA code to late effects of CVA code

Q: For a patient who had a stroke and is admitted to home care after the hospitalization for the stroke, is it correct to use 436, acute, but ill-defined, cerebrovascular disease (stroke), for the first 60-day episode, and a code from 438, late effects of cerebrovascular disease, thereafter?

A: As long as the patient is continuing to improve in response to the home health agency therapy, 436, stroke, would be an acceptable code. For example, if the documentation shows that the therapy is not for maintenance, but for restoration of function following the stroke, then the patient can still be considered in the immediate post-acute phase with an acute diagnosis (436). On the other hand, if the agency observes that the patient's recovery has reached a plateau, discharges the patient, and then readmits the patient several months later due to a loss of function, then a code from 438 is correct.

6. Alzheimer's Disease

Q: Before PPS we were told to avoid using Alzheimer's disease as a primary diagnosis. When is it acceptable as a primary diagnosis?

A: Alzheimer's disease is acceptable only when the agency is responsible for treating multiple aspects of the disease, such as educating the family in home adaptation, training in equipment use, instituting measures to prevent falls, and gait training. Alternatively, the agency may be involved in helping the patient and family to cope with multiple end-stage problems such as incontinence, dysphagia, decubiti, etc. Since the specific skilled nursing and therapeutic services needed in a typical Alzheimer's case are not obvious, the agency should ask itself the following types of questions: Is it a newly diagnosed case? Are there safety and education issues that create a need for skilled services? Is there a need for nursing assessment and monitoring for response to new medications? Is there a need for therapy to address functional declines that can be arrested? What other skilled nursing services are needed to address medical problems caused by the Alzheimer's disease?

7. Proper location of V-codes

Q: Can agencies ever use a V-code as the first secondary diagnosis?

A: No. V-codes are not allowed in any part of the OASIS assessment. Since the first two listed diagnoses must match on the UB-92, HCFA-485, and OASIS M0230/M0240, a V-code can never appear as the first secondary diagnosis. Agency staff should never try to "force" a V-code to be accepted during OASIS data entry by dropping the "v" character, because the resulting code is for an infectious disease. V-codes are permissible on the UB-92 (claim form) and the HCFA-485. On the UB-92, they must be positioned as the second secondary diagnosis or below. If there is no first secondary diagnosis, then omit the V-code because there should be no gaps in the diagnosis list on the UB-92. On the HCFA-485, the V-codes are generally placed in Box 21, Orders for Discipline and Treatments.

8. Burn wounds

Q: What is the correct ICD-9-CM coding for a primary diagnosis of wounds that are caused by burns?

A: The burn codes are in the code categories 940 to 949. There are detailed codes within these categories to indicate the site of the burn and to categorize the wound, such as blisters, full-thickness skin loss, or deep necrosis of underlying tissues with and without loss of a body part.

9. Erroneous coding of surgical wounds using trauma/injury codes

Q: We believe the CMS's intent was to allow HHAs to code surgical wounds using the codes in Table 8B, Burns and Trauma Diagnoses, of the Final PPS Rule. Please clarify.

A: The burn and trauma codes are in Chapter 17 of the ICD-9-CM manual, "Injury and Poisoning." These codes are used for wounds due to accidents and injuries, including

violence. They are not for surgery. In the case mix system, surgical wounds are addressed in the scoring for OASIS item M0488, surgical wound status. If the surgical wound is exhibiting early/partial granulation or not healing, then the grouper adjusts payment in accordance with the statistical results of the case mix study. The purpose of adding the burns and trauma codes to the scoring system was to make sure that the case mix adjuster covers categories of open wounds that are not addressed by any OASIS items used in the case mix model. The only way to identify wounds in the burns/trauma category is through diagnosis coding, since there are no OASIS items that ask specifically about burns/trauma. A V-code for "attention to surgical dressings and sutures" is available for use on the UB-92 and HCFA-485 as a secondary diagnosis code (with restrictions on placement as noted elsewhere in this document).

10. Correct coding for spontaneous fracture

Q: If the patient had a fracture due to severe bone thinning, and the fracture was not the result of a fall or other accident or violence, what is the correct diagnosis for the post-repair home care?

A: The home care in such cases is usually directed at care of the wound and perhaps rehabilitation. Since there is no surgical wound diagnosis code available, and V-codes for rehabilitation are not allowed on the OASIS, the primary diagnosis is pathological fracture (code 733.1x). Osteoporosis (733.0x) is incorrect because this diagnosis fails to indicate the acuteness of the condition and pathological fracture better describes the problems addressed by the agency. Traumatic fracture (categories 800-829) is also incorrect because the injury was not the result of an accident or violence.

11. Cardiac pacemaker

Q: What is the proper diagnosis code for a patient with a pacemaker who has home care because the nurse needs to monitor the pacemaker and ensure it is working properly?

A: If the patient had a pacemaker breakdown, displacement, or other mechanical complication, an appropriate primary diagnosis code is 996.01, mechanical complication of cardiac device, implant and graft, due to cardiac pacemaker. If the pacemaker malfunction caused a problem such as syncope, a secondary diagnosis code would be added (e.g., 780.2, cardiac syncope [from the symptom chapter]; 427.89, bradycardia). Code V53.31, Fitting and adjustment of cardiac pacemaker, is the appropriate code for monitoring of pacemaker function. However, this would be used as a secondary diagnosis following a diagnosis that relates to a skilled need; pacemaker monitoring alone is not a skilled service and therefore not an appropriate primary diagnosis.

12. Manifestation code placement

Q: When a manifestation code is used in conjunction with a paired primary diagnosis, does the grouper allow points for the paired codes if the manifestation code is placed in the primary diagnosis field? (For example, "polyneuropathy in diabetes" with ICD-9-CM

code 357.2 is placed in the primary diagnosis locator, and "diabetes with neurological manifestations" with ICD-9-CM code 250.6x is placed in the secondary diagnosis locator, and the primary reason for services is occupational therapy for the neuropathy.)

A: No. The correct way to code the primary diagnosis for treatment of the diabetic manifestation is 250.6x followed by the appropriate manifestation code. Points will be allowed for diabetes in the primary diagnosis field. Points associated with a manifestation are not allowed if the manifestation code is in the wrong position; it must always be in the second diagnosis field. Furthermore, the diagnosis in the primary field should make sense as an etiology for the manifestation.

13. Chapter 16 symptom codes as primary diagnoses

Q: There have been many coding articles published and conferences held stating Chapter 16 symptom codes should not be used as primary diagnoses. An example is an MS patient with urinary retention being seen for a Foley catheter change. Would it ever be correct to code the symptom as the primary diagnosis?

A: Yes. However, the correct primary diagnosis is usually neurogenic bladder, a codable diagnosis from the section on genitourinary disorders and, it so happens, a frequent aspect of MS. Because only one aspect of the MS is being treated, and because the V-code for Foley catheter change is not allowed on OASIS, urinary retention is the best diagnosis to report if the physician does not diagnose neurogenic bladder. The agency should ask the physician whether the patient has neurogenic bladder. Other times when a Chapter 16 symptom code is used is when the disease causing the symptom is not known or is not documented, or when the agency wants to avoid using a formerly applicable diagnosis, as in a post-surgical wound care case.

14. Allowable codes preceding manifestation codes

Q: In the list of ICD-9 CM diagnosis codes comprising the diagnostic groups for the home health resource group assignment, can the secondary diagnosis codes be used with any primary diagnosis or are there specific primary codes they can only be used with? Example: Primary diagnosis is 879.3, open wound of abdominal wall, complicated, and the secondary diagnosis is 713.8, arthopathy.

A: 713.8 is an arthropathy manifestation code, and it is highly doubtful the accidental abdominal wound led to arthropathy. Even if an infection of the wound ultimately caused the arthropathy, a different arthropathy code would be used, and it would be preceded by an infection code for a causal agent. This ordering would place the manifestation code as the third-listed diagnosis. For most manifestation codes, it would be very difficult to come up with a list of all possible diagnoses that might lead to the manifestation. For example, it would be very difficult to list all the possible etiology codes for the manifestation code 331.7 (Cerebral degeneration in diseases classified elsewhere). However, there must be a cause-effect relationship between the first diagnosis and the second one (manifestation code) in order for the second one to be valid. Also, the cause must make sense in view of

the category of manifestation code chosen (as the arthropathy example shows). These requirements will automatically exclude some diagnoses as predecessors.

15. Medical amputation

Q: What would be the primary diagnosis code for a diabetic patient who is now receiving therapy for gait training following a below-the-knee amputation caused by diabetic circulatory disorders that led to gangrene--diabetes or abnormality of gait?

A: A diabetic manifestation is not the reason for home health services; therefore, the diabetes does not need to be sequenced first. And the symptom the patient currently has is not due directly to the diabetes, or any other definitive diagnosis, and, therefore, a definitive diagnosis code does not need to be sequenced first. Assuming the focus of home health care is PT for the abnormality of gait, the code for abnormality of gait should be listed first. While it is true that the abnormality of gait code is a Chapter 16 symptom code, the abnormality of gait is not due to the diabetes or the diabetic gangrene. It is due to the fact that the patient is missing a leg. And while the amputation is due to the diabetic condition, the abnormal gait resulting from the amputation is not due to the diabetic condition - it is due to the surgery. Therefore, the code for abnormality of gait should be the primary diagnosis.

Ordinarily, under ICD-9-CM guidelines, a V-code for the therapy would be best as the primary diagnosis, since that provides a direct reason for the therapy treatment, but V-codes are forbidden by OASIS as home care diagnoses. Also, since this question concerns a medical amputation, mention of an amputation from the Injury and Poisoning chapter would be wrong. Codes in the Injury and Poisoning chapter are reserved for injuries from accidents and violence (with the exception of complications codes in categories 996-999).

16. Infected insect bite

Q: How should a debrided infected insect bite be coded? Is it correct to report the primary diagnosis as an open wound trauma code, 894.1?

A: No. There are codes in 910-919 for infected insect bites in the superficial injuries section.

17. Coding practice resources

Q: Where can I get information about current issues in ICD-9-CM diagnosis coding?

A: The official publication for ICD-9-CM coding guidelines and advice is the quarterly "Coding Clinic for ICD-9-CM," available through the American Hospital Association. The information in Coding Clinic is developed in cooperation with AHIMA and the federal government. The publication presents short articles and a section with questions and answers.